services are reviewed and paid if they are medically appropriate for the condition treated, even though the condition was not an emergency. Ancillary services which are denied as not medically appropriate for treatment of the condition may not be billed to the recipient.

e. Emergency room services rendered in conjunction with an inpatient admission should be included on the claim form with charges for inpatient care. In such cases, emergency room services will be reimbursed in accordance with the inpatient reimbursement methodology.

STATE New Mexico
DATE REC'D 6-23-92
DATE APPV'D 7-21-92
DATE EFF 4-1-92
HCFA-179 92-10
A

Supersedes TN 91-22

VI. For laboratory services, payment does not exceed maximum levels allowed by the Title XVIII carrier.

VII. Payment for dental prostheses is made using the same methodology for professional services as outlined in Section I of this attachment.

Payment for durable medical equipment and prosthetic and orthotic appliances is made at the lesser of the provider's billed charge or the current Medicare fee schedule when a fee schedule amount is available.

Effective January 1, 1996, when a Medicare fee schedule amount is not available durable medical equipment is reimbursed at the actual acquisition cost plus 25 percent when the actual acquisition cost is less than $1,000. When the actual acquisition cost is $1,000 or more, reimbursement is limited to actual acquisition cost plus 15 percent.

Payment for parenteral and enteral nutrition products is made at amounts which do not exceed those paid by Medicare.

Payment for glasses is made at invoice cost for materials subject to a limit on reimbursement for frames. This limit, as well as payment for dispensing eye glasses, is made at a level established by the Department which considers payment practices of other third party organizations, negotiations with appropriate professional societies, and the usual charges of the providers for services to non-Medicaid patients.

VIII. Rural Health Clinics and Federally Qualified Health Centers

a. Payment to rural health clinics is made at a reasonable cost rate per visit as established by the Title XVIII carrier in accordance with Federal Regulation 42 CFR Sections 405.2426-405.2429. Services provided by rural health clinics covered under the state plan but not part

STATE Tenn Review
DATE 03-29-96
DATE 05-22-96
DATE EFF 01-01-96
HCFA 179 96-04
A

SUPERSEDES: TN - 92-06

of the Medicare all-inclusive rate will be reimbursed in accordance with regular reimbursement procedures as described in other sections of the State Plan.

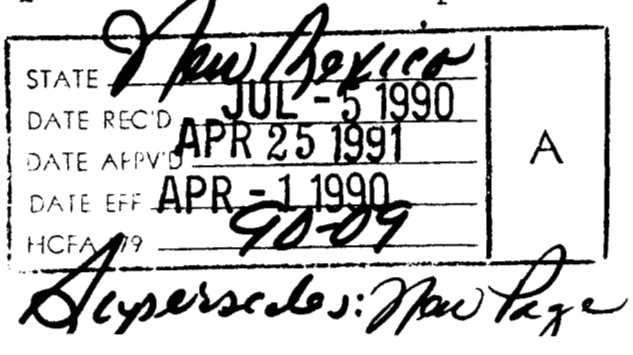
b. Federally Qualified Health Clinic (FQHC) reimbursement is made using an interim encounter rate determined by the audit agent which is reconciled to 100% of reasonable cost at the end of each FQHC's fiscal reporting period. Allowed costs for reimbursement and reconciliation purposes will be determined by the audit agent through application of the Medicare cost reimbursement principles in 42 CFR Part 413. For outpatient services that the FQHC contracts to provide, reasonable costs for such services will be determined by the cost reimbursement principles described in 42 CFR Part 413. The Medical Assistance Division assures that using these principles, reimbursement will be made at 100% of the reasonable costs of providing services to Medicaid recipients.

1. Providers will submit a cost report to the audit agent on a modified HCFA-242 form. The initial cost report will be due no later than 90 days after the FQHC's effective date. Subsequent cost reports will be due no later than 90 days after the end of the clinic's fiscal reporting period (year).

2. These cost settlements will reconcile the interim reimbursement to 100% of reasonable costs as provided for in Section 1902 (a)(13) (E) of the Social Security Act, as amended to include reference to FQHC's.

3. The cost settlement amount will be equal to 100% of reasonable cost to provide allowable services to Medicaid recipients, less the amount reimbursed through interim payments. Notification of cost settlement amounts will be forwarded to the Medical Assistance Division who will generate an accounting transaction request to the fiscal agent to remit the amount due to the FQHC. If an amount is due to the state from the FQHC, a demand letter will be mailed to the FQHC.

4. Cost settlements may be calculated for each individual clinic or one settlement for all clinics within the satellite group at the FQHC administration's option.



IX. Payment for hospice service is made according to the reimbursement rate schedule and local adjustment methodology as outlined in the State Medicaid Manual, Hospice services, Section 4306 -4308. Payment to a hospice for inpatient care are limited to 20 percent of the aggregate total number of hospice care days during a cap period from November 1 to October 31 of each year. The benefit does not exercise an option to cap overall reimbursement made to a hospice during the cap period. When hospice care is furnished to an individual residing in a nursing facility, the hospice is paid an additional amount on routine home care and continuous home care days furnished by the facility. The additional amount paid to the hospice on behalf of an individual residing in a nursing facility equals at least 95 percent of the per diem rate that would have been paid to the nursing facility for that individual in that facility under this State Plan. For dually eligible recipients residing in a Medicaid - reimbursed long term care facility and electing Medicare hospice, Medicaid will reimburse the hospice for drug and respite care co-payments as well as room and board services.

The rate increase created by OBRA '90 that went into effect October 1, 1990 will continue through the end of 1990.

Payment to a hospice for physician services is made in accordance with the usual Medicaid reimbursement policy for physician services as the usual Medicaid reimbursement policy for physician services as outlined in Section I of this attachment. Physician services include direct care services furnished to individual hospice patients by hospice employees and physician services furnished under arrangements made by the hospice unless the patient care services were furnished on a volunteer basis.

Payment for services related to the terminal illness or related conditions and unique to Title XIX will be made according to the reimbursement policies set forth in the New Mexico Medicaid Program Manual.

STATE New Mexico
DATE REC'D 6-19-91
DATE APPV'D 7-2-91
DATE EFF 4-1-91
HCFA ID 91-10
A
Supersedes: 90-25

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. a. Payment of Targeted Case Management Services for individuals who are chronically mentally ill.

The Department considered the prevailing charges and existing fees schedule for services similar to case management responsibilities in complexity, time and level of responsibility. The fee was established at $12.50 per 15 minute unit of service. The reasonableness of the fee was verified by comparing the fee to the case management fees paid by other states Medicaid programs for similar services and to payments made by other payors in New Mexico for case management services. Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

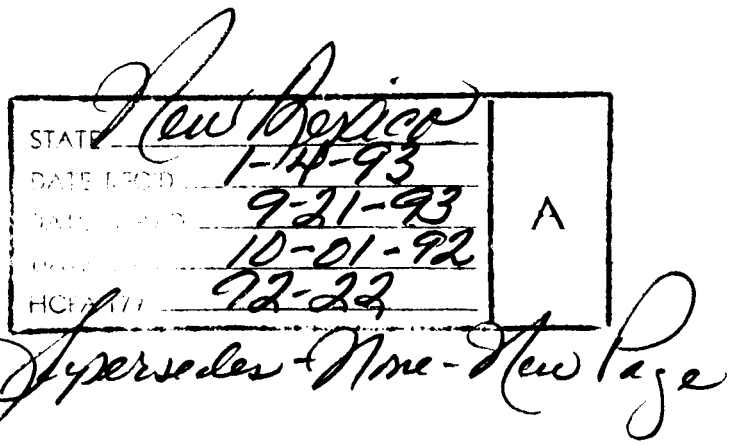
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. b. Payment of Targeted Case Management Services for adults who are developmentally disabled.

The Department used cost studies developed by a consulting firm in 1991 to determine the average actual costs to providers to perform case management services. Allowables include salaries plus fringe benefits, costs for supervision, costs for direct operating expenses, facility related costs, and staff costs for indirect administration. Salaries for case managers were based on that of a State Social Worker adjusted for two years tenure at 4% per year. Case loads were based on a 1:30 staff/consumer ratio. Using these factors, a fee for service cost was determined which may be billed utilizing a monthly unit rate of $189.00. Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. c. Payment of Targeted Case Management Services for pregnant women and their infants for up to 60 days after their birth.

The Department considered the prevailing charges and existing fees schedule for services similar to case management responsibilities in complexity, time and level of responsibility. The fee was established at $12.50 per 15 minute unit of service. The reasonableness of the fee was verified by comparing the fee to the case management fees paid by other states Medicaid programs for similar services and to payments made by other payors in New Mexico for case management services. Reimbursement for case management services is consistent with the requirement os Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

STATE
DATE REC'D JAN 04 1993
DATE APPV'D SEP 21 1993
DATE EFF OCT 01 1992
HCFA 179
A

Supersedes: None - New Page

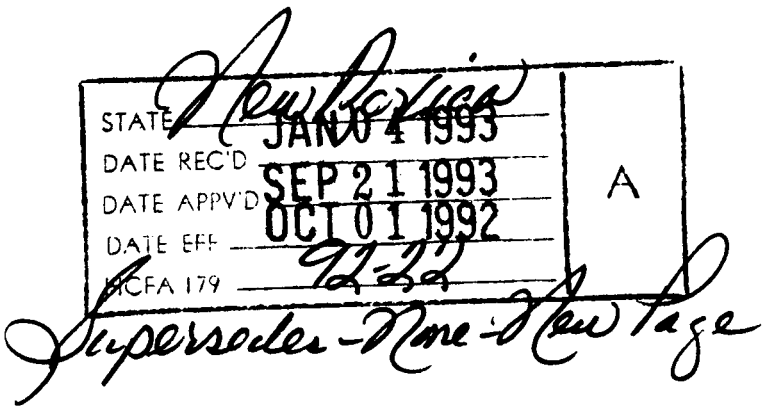
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. d. Payment of Targeted Case Management Services for children up to age three.

The Department considered the prevailing charges and existing fees schedule for services similar to case management responsibilities in complexity, time and level of responsibility. The fee was established at $12.50 per 15 minute unit of service. The reasonableness of the fee was verified by comparing the fee to the case management fees paid by other states Medicaid programs for similar services and to payments made by other payors in New Mexico for case management services. Reimbursement for case management services is consistent with the requirements in Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. e. Payment of Targeted Case Management Services for individuals who are traumatically brain injured.

The Department considered the prevailing charges and existing fees schedule for services similar to case management responsibilities in complexity, time and level of responsibility. The fee was established at $12.50 per 15 minute unit of service. The reasonableness of the fee was verified by comparing the fee to the case management fees paid by other states Medicaid programs for similar services and to payments made by other payors in New Mexico for case management services. Reimbursement for case management services is consistent with the requirements of Section 1902(a)(30) of the Act and 42 CFR 447.200 which stipulate that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.

STATE New Mexico
DATE REC'D 8-27-93
DATE APP'VD 1-27-94
DATE EFF 8-1-93
HCFA-179 93-18
A

Supersedes None New Page

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE: NEW MEXICO

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Item X. e. Payment of Targeted Case Management Services for adult individuals who have been abused, neglected or exploited.

The Medicaid client case management unit rate is determined by dividing the adjusted field services budget by the total Medicaid client case management eligibles. Because field service personnel perform non case management services and they service non Medicaid clients, the total field service budget is adjusted to exclude all field service related costs not related to case management activities. It is further adjusted to exclude non Medicaid eligible case management clients. A random sampling of the field workers time is performed to assist in computing the amount to adjust. This unit rate is reviewed every year and adjustments made as necessary to reflect any over or under payments from the prior year, and is performed within three months after the closing of the subject year.

The Department used a case management rate methodology developed and applied by the Children, Youth and Families Department (CYFD) to determine the actual costs to providers. Allowable are salaries plus fringe benefits, costs for supervision, costs for indirect administration. A fee for service cost was determined which will be billed using a monthly unit rate. Claims are prepared by CYFD and transmitted to the Human Services Department on a monthly basis.

Reimbursement for case management services is consistent with the requirements of Section 1902 (a) (30) of the Act and 42 CFR 447.200 which stipulates that payments for services must be consistent with efficiency, economy, and quality of care. It was also determined that the rates are in conformance with OMB Circular A-87.